FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044453

Facility Name: PINNACLE HEALTH CARE

Address: 2222 WEST 14TH STREE (Number) WAUKEGAN (City) 60085 (Zip Code)

County: LAKE

Telephone Number: (847) 249-2400 **Fax #** (847) 249-0536

IDPA ID Number: 364302186001

Date of Initial License for Current Owners: 08/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) Edward N. Slack, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	125	Skilled (SNF)	125	45,625	1
2		Skilled Pediatric (SNF/PED)			2
3	146	Intermediate (ICF)	146	53,290	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	271	TOTALS	271	98,915	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,730	1,937	7,844	31,511	8
9	SNF/PED					9
10	ICF	39,465	2,850	1,166	43,481	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,195	4,787	9,010	74,992	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.81%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Child Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/1/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 6,808

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	361,094	45,022	12,096	418,212		418,212	132	418,344			1
2	Food Purchase		352,045		352,045	(47,304)	304,741	6	304,747			2
3	Housekeeping	203,096	63,885		266,981		266,981		266,981			3
4	Laundry	95,836	25,613		121,449		121,449		121,449			4
5	Heat and Other Utilities			199,478	199,478		199,478	2,524	202,002			5
6	Maintenance	103,395		93,708	197,103		197,103	6,237	203,340			6
7	Other (specify):*							1,319	1,319			7
8	TOTAL General Services	763,421	486,565	305,282	1,555,268	(47,304)	1,507,964	10,218	1,518,182			8
	B. Health Care and Programs											
9	Medical Director			33,000	33,000		33,000		33,000			9
10	Nursing and Medical Records	3,086,199	216,621	14,519	3,317,339		3,317,339	(10,311)	3,307,028			10
10a	Therapy	157,808	2,011	9,215	169,034		169,034		169,034			10a
11	Activities	165,935	9,000	2,496	177,431		177,431	2	177,433			11
12	Social Services	180,417		5,965	186,382		186,382	16	186,398			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							5,410	5,410			15
16	TOTAL Health Care and Programs	3,590,359	227,632	65,195	3,883,186		3,883,186	(4,883)	3,878,303			16
	C. General Administration											
17	Administrative	105,214		156,000	261,214		261,214	39,425	300,639			17
18	Directors Fees											18
19	Professional Services			209,346	209,346		209,346	(141,738)	67,608			19
20	Dues, Fees, Subscriptions & Promotions			47,887	47,887		47,887	(28,671)	19,216			20
21	Clerical & General Office Expenses	100,224	29,589	194,520	324,333		324,333	2,011	326,344			21
22	Employee Benefits & Payroll Taxes			669,778	669,778	47,304	717,082		717,082			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,675	6,675		6,675	4,907	11,582			24
25	Other Admin. Staff Transportation			655	655		655		655			25
26	Insurance-Prop.Liab.Malpractice			153,184	153,184		153,184	5,481	158,665			26
27	Other (specify):*							22,485	22,485			27
28	TOTAL General Administration	205,438	29,589	1,438,045	1,673,072	47,304	1,720,376	(96,100)	1,624,276			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,559,218	743,786	1,808,522	7,111,526		7,111,526	(90,765)	7,020,761			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PINNACLE HEALTH CARE #0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			150,913	150,913		150,913	(42,377)	108,536			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			154,322	154,322		154,322	25,920	180,242			32
33	Real Estate Taxes			133,578	133,578		133,578	3,369	136,947			33
34	Rent-Facility & Grounds			1,256,476	1,256,476		1,256,476	17,908	1,274,384			34
35	Rent-Equipment & Vehicles			19,033	19,033		19,033	5,697	24,730			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,714,322	1,714,322		1,714,322	10,517	1,724,839			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	98,435	357,155	313,574	769,164		769,164	(27,019)	742,145			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			148,373	148,373		148,373		148,373			42
43	Other (specify):*	32,094		2,508	34,602		34,602	(34,602)				43
44	**TOTAL Special Cost Centers**	130,529	357,155	464,455	952,139		952,139	(61,621)	890,518			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,689,747	1,100,941	3,987,299	9,777,987		9,777,987	(141,869)	9,636,118			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(117,917)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(225)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(116,775)	21		24
25	Fund Raising, Advertising and Promotional	(23,489)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,098)	20		28
29	Other-Attach Schedule	(110,331)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (369,835)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	227,966		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 227,966		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (141,869)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

PINNACLE HEALTH CARE

ID# 0044453

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VA Expense	$ (43,320)	10	1
2	Bank Charges	(18,642)	21	2
3	Theft Loss	(75)	21	3
4	ICLTC - COPE	(6,568)	20	4
5	Day Care Expenses	(34,602)	43	5
6	Misc Income	(7,124)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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96				96
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98				98
99				99
100				100
101	Total	(110,331)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					5,915	(5,783)						132	1
2	Food Purchase	(225)		(167)			398						6	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,941				583					2,524	5
6	Maintenance			3,797		2,246	5	189					6,237	6
7	Other (specify):*					1,103	216						1,319	7
8	**TOTAL General Services**	(225)		5,571		9,264	(5,164)	772					10,218	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(43,320)		(47)		13,919	3	19,134					(10,311)	10
10a	Therapy													10a
11	Activities			2									2	11
12	Social Services					16							16	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*					1,917		3,493					5,410	15
16	**TOTAL Health Care and Programs**	(43,320)		(45)		15,852	3	22,627					(4,883)	16
	C. General Administration													
17	Administrative			457		38,883	85						39,425	17
18	Directors Fees													18
19	Professional Services			(54,103)			170	(87,805)					(141,738)	19
20	Fees, Subscriptions & Promotions	(31,155)		1,502			9	973					(28,671)	20
21	Clerical & General Office Expenses	(142,616)		18,726		111,022	122	14,757					2,011	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,117			182	3,608					4,907	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,365				4,116					5,481	26
27	Other (specify):*					21,119		1,366					22,485	27
28	**TOTAL General Administration**	(173,771)		(30,936)		171,024	568	(62,985)					(96,100)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(217,316)		(25,410)		196,140	(4,593)	(39,586)					(90,765)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(117,917)		13,382				15,235		46,923			(42,377)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			14,272				4,120		7,528			25,920	32
33	Real Estate Taxes			3,369									3,369	33
34	Rent-Facility & Grounds			5,204			5	12,699					17,908	34
35	Rent-Equipment & Vehicles			3,780			7	1,910					5,697	35
36	Other (specify):*													36
37	TOTAL Ownership	(117,917)		40,007			12	33,964		54,451			10,517	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						2,981			(30,000)			(27,019)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(34,602)											(34,602)	43
44	TOTAL Special Cost Centers	(34,602)					2,981			(30,000)			(61,621)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(369,835)		14,597		196,140	(1,600)	(5,622)		24,451			(141,869)	45

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				Northshore Properties, LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income / Expense	$ 1,256,476	Northshore Properties	100.00%	$ 1,256,476	$	1
2	V	33	RE Tax Income / Expense	123,507	Northshore Properties	100.00%	123,507		2
3	V	32	Interest Income / Expense	38,428	Northshore Properties	100.00%	38,428		3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,418,411			$ 1,418,411	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	05	Utilities	$	Care Centers, Inc.	100.00%	$ 1,941	$ 1,941	15
16	V	06	Maintenance		Care Centers, Inc.	100.00%	3,797	3,797	16
17	V	10	Nursing	56	Care Centers, Inc.	100.00%	9	(47)	17
18	V	11	Activities		Care Centers, Inc.	100.00%	2	2	18
19	V	19	Professional Fees	65,412	Care Centers, Inc.	100.00%	11,309	(54,103)	19
20	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	1,502	1,502	20
21	V	21	Office & Clerical		Care Centers, Inc.	100.00%	18,726	18,726	21
22	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	1,117	1,117	22
23	V	26	Insurance		Care Centers, Inc.	100.00%	1,365	1,365	23
24	V	30	Depreciation		Care Centers, Inc.	100.00%	13,382	13,382	24
25	V	32	Interest		Care Centers, Inc.	100.00%	14,272	14,272	25
26	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	3,369	3,369	26
27	V	34	Rent - Building		Care Centers, Inc.	100.00%	5,204	5,204	27
28	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	3,780	3,780	28
29	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			29
30	V	02	Food	167	Care Centers, Inc.	100.00%		(167)	30
31	V	17	Administration		Care Centers, Inc.	100.00%	457	457	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 65,635			$ 80,232	$ * 14,597	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping Salary	$	Care Centers, Inc.	100.00%	$	$	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%			17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%			18
19	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			19
20	V	11	Activity Salary		Care Centers, Inc.	100.00%			20
21	V	12	Social Service Salary		Care Centers, Inc.	100.00%			21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%			22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%			23
24	V	21	Office Salary		Care Centers, Inc.	100.00%			24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%			25
26	V	22	Employee Benefits		Care Centers, Inc.	100.00%			26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Care Centers, Inc.	100.00%	$ 5,915	$ 5,915	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	2,246	2,246	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,103	1,103	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%	13,919	13,919	18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	16	16	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,917	1,917	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	38,883	38,883	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	111,022	111,022	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	21,119	21,119	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 196,140	$ * 196,140	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 8,061	Care Centers, Inc. - Health Systems Division	100.00%	$ 671	$ (7,390)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	398	398	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	5	5	17
18	V	10	Nursing		Care Centers, Inc. - Health Systems Division	100.00%	3	3	18
19	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	85	85	19
20	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	170	170	20
21	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	9	9	21
22	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	122	122	22
23	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	182	182	23
24	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	5	5	24
25	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	7	7	25
26	V	39	Ancillary Enteral Supplies		Care Centers, Inc. - Health Systems Division	100.00%	2,981	2,981	26
27	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,607	1,607	27
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	216	216	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,061			$ 6,461	$ * (1,600)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	05	Utilities	$	Pinnacle Care Health Services, LLC	100.00%	$ 583	$ 583	15
16	V	06	Maintenance		Pinnacle Care Health Services, LLC	100.00%	189	189	16
17	V	10	Nursing		Pinnacle Care Health Services, LLC	100.00%	19,134	19,134	17
18	V	15	Emp. Ben. - Healthcare		Pinnacle Care Health Services, LLC	100.00%	3,493	3,493	18
19	V	19	Professional Fees	89,280	Pinnacle Care Health Services, LLC	100.00%	1,475	(87,805)	19
20	V	20	Dues and Subscriptions	304	Pinnacle Care Health Services, LLC	100.00%	1,277	973	20
21	V	21	Office & Clerical		Pinnacle Care Health Services, LLC	100.00%	14,757	14,757	21
22	V	24	Travel and Seminar		Pinnacle Care Health Services, LLC	100.00%	3,608	3,608	22
23	V	26	Insurance		Pinnacle Care Health Services, LLC	100.00%	4,116	4,116	23
24	V	27	Emp. Ben. - Gen. Admin.		Pinnacle Care Health Services, LLC	100.00%	1,366	1,366	24
25	V	30	Depreciation		Pinnacle Care Health Services, LLC	100.00%	15,235	15,235	25
26	V	32	Interest		Pinnacle Care Health Services, LLC	100.00%	4,120	4,120	26
27	V	33	Real Estate Taxes		Pinnacle Care Health Services, LLC	100.00%			27
28	V	34	Rent - Building		Pinnacle Care Health Services, LLC	100.00%	12,699	12,699	28
29	V	35	Rent - Equipment & Auto		Pinnacle Care Health Services, LLC	100.00%	1,910	1,910	29
30	V	25	Bus Reimbursement		Pinnacle Care Health Services, LLC	100.00%			30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 89,584			$ 83,962	$ * (5,622)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 128,867	$ 128,867	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	128,867				(128,867)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 128,867			$ 128,867	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 46,923	$ 46,923	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	7,528	7,528	16
17	V	39	Vent Reimbursement	30,000	Vent Lease, LLC.	100.00%		(30,000)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 30,000			$ 54,451	$ * 24,451	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0	see attached	1	1.39%	Mgmt Fees	$ 60,000	17-3	1
2	Barry Gans	Owner	Asst. Admin.	35.42%	see attached	25	38.47%	Mgmt Fees	96,000	17-3	2
3	Barry Gans	Owner	Asst. Admin.	35.42%	see attached	25	38.47%	Salary	18,469	17-1	3
4	Mark Steinberg	Relative	Administrative	0	see attached	2.29	4.58%	CCI alloc	2,069	17-7	4
5	Melissa Rothner	Owner	Clerical	8.98%	see attached			CCI alloc	46	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 176,584		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	05	Utilities	Patient Days	1,640,756	39	$ 42,470	$	74,992	$ 1,941	1
2	06	Maintenance	Patient Days	1,640,756	39	83,080		74,992	3,797	2
3	10	Nursing	Patient Days	1,640,756	39	205		74,992	9	3
4	11	Activities	Patient Days	1,640,756	39	51		74,992	2	4
5	19	Professional Fees	Patient Days	1,640,756	39	247,437		74,992	11,309	5
6	20	Dues and Subscriptions	Patient Days	1,640,756	39	32,863		74,992	1,502	6
7	21	Office & Clerical	Patient Days	1,640,756	39	409,698		74,992	18,726	7
8	24	Travel and Seminar	Patient Days	1,640,756	39	53,743		74,992	1,117	8
9	26	Insurance	Patient Days	1,640,756	39	29,875		74,992	1,365	9
10	30	Depreciation	Patient Days	1,640,756	39	292,776		74,992	13,382	10
11	32	Interest	Patient Days	1,640,756	39	312,254		74,992	14,272	11
12	33	Real Estate Taxes	Patient Days	1,640,756	39	73,702		74,992	3,369	12
13	34	Rent - Building	Patient Days	1,640,756	39	113,857		74,992	5,204	13
14	35	Rent - Equipment & Auto	Patient Days	1,640,756	39	82,710		74,992	3,780	14
15	17	Administration	Patient Days	1,640,756	39	10,000		74,992	457	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,784,721	$		$ 80,232	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping Salary	Direct Cost			45,667	45,667			1
2	06	Maintenance Salary	Direct Cost			169,934	169,934			2
3	07	Emp. Ben. - Gen. Serv.	Direct Cost			29,646				3
4	10	Nursing Salary	Direct Cost			895,582	895,582			4
5	10a	Rehab Salary	Direct Cost			128,376	128,376			5
6	11	Activity Salary	Direct Cost			57,201	57,201			6
7	12	Social Service Salary	Direct Cost			219,790	219,790			7
8	15	Emp. Ben. - Healthcare	Direct Cost			180,204				8
9	17	Administration Salary	Direct Cost			1,334,207	1,334,207			9
10	21	Office Salary	Direct Cost			584,278	584,278			10
11	27	Emp. Ben. - Gen. Admin.	Direct Cost			267,060				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,911,943	$ 3,435,033		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,640,756	39	129,417	129,417	74,992	5,915	1
2	06	Maintenance Salary	Patient Days	1,640,756	39	49,148	49,148	74,992	2,246	2
3	07	Emp. Ben. - Gen. Serv.	Patient Days	1,640,756	39	24,132		74,992	1,103	3
4	10	Nursing Salary	Patient Days	1,640,756	39	304,530	304,530	74,992	13,919	4
5	12	Social Service Salary	Patient Days	1,640,756	39	354	354	74,992	16	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,640,756	39	41,952		74,992	1,917	6
7	17	Administration Salary	Patient Days	1,640,756	39	850,731	850,731	74,992	38,883	7
8	21	Office Salary	Patient Days	1,640,756	39	2,429,052	2,429,052	74,992	111,022	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,640,756	39	462,069		74,992	21,119	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,291,386	$ 3,763,233		$ 196,140	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,191,458		182,448		8,061	671	1
2	02	Food	Billable Income	2,191,458		834,365		8,061	398	2
3	06	Maintenance	Billable Income	2,191,458		1,400		8,061	5	3
4	10	Nursing	Billable Income	2,191,458		850		8,061	3	4
5	17	Administration	Billable Income	2,191,458		23,000		8,061	85	5
6	19	Professional Fees	Billable Income	2,191,458		46,205		8,061	170	6
7	20	Dues & Subscriptions	Billable Income	2,191,458		2,514		8,061	9	7
8	21	Office & Clerical	Billable Income	2,191,458		33,124		8,061	122	8
9	24	Travel & Seminar	Billable Income	2,191,458		49,456		8,061	182	9
10	34	Rent - Building	Billable Income	2,191,458		1,300		8,061	5	10
11	35	Rent - Equipment & Auto	Billable Income	2,191,458		1,830		8,061	7	11
12	39	Ancillary Enteral Supplies	Billable Income	2,191,458		84,436		8,061	2,981	12
13	01	Dietary - Salary	Billable Income	2,191,458		436,887	436,887	8,061	1,607	13
14	07	Emp. Ben. - Gen. Serv.	Billable Income	2,191,458		58,714		8,061	216	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,756,530	$ 436,887		$ 6,461	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Pinnacle Care Health Services, LLC
Street Address: 1010 Milwaukee Avenue
City / State / Zip Code: Deerfield, Illinois 60015
Phone Number: (847) 541-9100
Fax Number: (847) 541-9015

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	05	Utilities	Patient Days	159,089	3	$ 1,238	$	74,992	$ 583	1
2	06	Maintenance	Patient Days	159,089	3	400		74,992	189	2
3	10	Nursing	Patient Days	159,089	3	40,591	40,591	74,992	19,134	3
4	15	Emp. Ben. - Healthcare	Patient Days	159,089	3	7,409		74,992	3,493	4
5	19	Professional Fees	Patient Days	159,089	3	3,130		74,992	1,475	5
6	20	Dues and Subscriptions	Patient Days	159,089	3	2,709		74,992	1,277	6
7	21	Office & Clerical	Patient Days	159,089	3	31,307	14,681	74,992	14,757	7
8	24	Travel and Seminar	Patient Days	159,089	3	7,653		74,992	3,608	8
9	26	Insurance	Patient Days	159,089	3	8,731		74,992	4,116	9
10	27	Emp. Ben. - Gen. Admin.	Patient Days	159,089	3	2,899		74,992	1,366	10
11	30	Depreciation	Patient Days	159,089	3	32,319		74,992	15,235	11
12	32	Interest	Patient Days	159,089	3	8,741		74,992	4,120	12
13	33	Real Estate Taxes	Patient Days	159,089	3			74,992		13
14	34	Rent - Building	Patient Days	159,089	3	26,940		74,992	12,699	14
15	35	Rent - Equipment & Auto	Patient Days	159,089	3	4,051		74,992	1,910	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 178,117	$ 55,272		$ 83,962	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 W. MAIN ST.
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-4000
Fax Number: (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 128,867	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 128,867	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 4101 W. Main Street
City / State / Zip Code: Skokie, Illinois 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Patient Days	343,608	5	$ 215,000	$	74,992	$ 46,923	1
2	32	Interest	Patient Days	343,608	5	34,494		74,992	7,528	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 249,494	$		$ 54,451	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Premier Bank		X	Auto Loan			$	$			$ 3,651	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIB Bank		X	Line of Credit				2,015,993			109,433	6
7												7
8	Shareholder Loan	X									38,428	8
9	TOTAL Facility Related						$	$ 2,015,993			$ 151,512	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										28,729	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 28,729	14
15	TOTALS (line 9+line14)						$	$ 2,015,993			$ 180,241	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Insurance Financing						$	$			$ 2,809	1
2	Ventlease allocation										7,528	2
3	Pinnacle Care allocation										4,120	3
4	Care Centers allocation										14,272	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 28,729	21

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	102,148	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	118,358	2
3. Under or (over) accrual (line 2 minus line 1).	$	16,210	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	120,737	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	136,947	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999	39,064	10
2000	97,284	11
2001	114,989	12

2002 accrual = $114,989 x 1.05 = $120,737

Allocated from Care Centers $3369

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PINNACLE HEALTH CARE COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0044453

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-32-109-021	Long Term Care Property	$ 114,988.85	$ 114,988.85
2.	see attached	Care Centers allocation	$ 70,261.69	$ 3,211.36
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 185,250.54	$ 118,200.21

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PINNACLE HEALTH CARE COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0044453

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,925 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Child Care - 800 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2	Care Centers allocation			19,224	2
3	TOTALS			$ 19,224	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		51,021	2,128		2,185	57	176	68
69	Financial Statement Depreciation			71,297			(71,297)		69
70	TOTAL (lines 4 thru 69)		$ 51,021	$ 73,425		$ 2,185	$ (71,240)	$ 176	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 51,021	$ 73,425		$ 2,185	$ (71,240)	$ 176	1
2	PAINT & DECOR	1999	1,649		20	82	82	258	2
3	SPRINKLER	1999	1,530		20	77	77	242	3
4	CARPET	1999	9,400		20	470	470	1,480	4
5	CARPET	1999	2,689		20	134	134	416	5
6	PAINT & DECORATING	1999	2,081		20	104	104	319	6
7	PAINTING & DECOR	1999	2,002		20	100	100	306	7
8	ELEVATOR RENOV	1999	5,500		20	275	275	831	8
9	ELEC RENOV	1999	11,411		20	571	571	1,725	9
10	BLDG RENOV	1999	22,800		20	1,140	1,140	3,444	10
11	PAINT & DECOR	1999	2,530		20	127	127	384	11
12	FIXTURES	1999	7,477		20	374	374	1,122	12
13	FIXTURES	1999	1,400		20	70	70	210	13
14	SIGNS	1999	701		20	35	35	105	14
15	BLDG RENOVATIONS	2000	16,200		20	810	810	2,430	15
16	PAINT & DECORATE	2000	11,507		20	575	575	1,725	16
17	ELECTRICAL RENOV	2000	1,198		20	60	60	180	17
18	ELEVATOR RENOV	2000	6,431		20	322	322	966	18
19	CARPETING	2000	1,320		20	66	66	193	19
20	SUMP PUMP	2000	3,225		20	161	161	470	20
21	HVAC RENOV	2000	4,966		20	248	248	723	21
22	WIRING/OUTLETS	2000	11,000		20	550	550	1,604	22
23	PAINT & DECORATE	2000	620		20	31	31	90	23
24	PAINT & DECORATE	2000	2,146		20	107	107	303	24
25	ELECTRICAL	2000	2,060		20	103	103	292	25
26	PLASTER/ELECTRICAL	2000	5,425		20	271	271	768	26
27	WIRING/OUTLETS	2000	12,420		20	621	621	1,760	27
28	PLUMBING RENOV	2000	4,260		20	213	213	586	28
29	CARPETING	2000	1,465		20	73	73	201	29
30	PLUMBING RENOV	2000	4,000		20	200	200	533	30
31	ELEVATOR MODULE	2000	2,568		20	128	128	341	31
32	HVAC	2000	1,445		20	72	72	192	32
33	BLDG RENOV	2000	9,500		20	475	475	1,188	33
34	TOTAL (lines 1 thru 33)		$ 223,947	$ 73,425		$ 10,830	$ (62,595)	$ 25,563	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 223,947	$ 73,425		$ 10,830	$ (62,595)	$ 25,563	1
2	HVAC	2000	2,080		20	104	104	260	2
3	PLUMBING	2000	7,737		20	387	387	935	3
4	HVAC	2000	1,419		20	71	71	172	4
5	PLUMBING	2000	4,400		20	220	220	513	5
6	FENCE	2000	3,441		20	172	172	401	6
7	ELEVATOR RENOV	2000	1,089		20	54	54	126	7
8	PLUMBING	2000	8,125		20	406	406	914	8
9	CARPETING	2000	200		20	10	10	23	9
10	BLDG RENOV	2000	950		20	48	48	108	10
11	HVAC	2000	954		20	48	48	108	11
12	ELECTRICAL RENOV	2000	1,702		20	85	85	191	12
13	FIRE ALARM SYSTEM	2000	1,668		20	83	83	180	13
14	SMOKE DETECTORS	2000	13,040		20	652	652	1,413	14
15	HVAC	2000	4,024		20	201	201	436	15
16	CUBICLE CURTAINS	2000	5,024		20	251	251	523	16
17	COUNTERTOP	2000	6,650		20	333	333	944	17
18	BLDG RENOV	2000	911		20	46	46	111	18
19	PAINTING & DECOR	2001	31,420		20	1,571	1,571	3,011	19
20	WALLPAPER	2001	4,521		20	226	226	433	20
21	CARPET	2001	2,195		20	220	220	422	21
22	COOLING TOWER	2001	25,190		20	1,260	1,260	2,310	22
23	LABOR	2001	9,920		20	496	496	827	23
24	WALLPAPER	2001	3,790		20	190	190	317	24
25	COOLING TOWER	2001	757		20	38	38	51	25
26	WALLPAPER	2001	6,715		20	336	336	392	26
27	SECURITY CAMERA	2001	1,992		20	100	100	200	27
28	PHONE	2001	11,000		20	550	550	825	28
29	PHONES	2001	11,200		20	560	560	793	29
30	SIGN	2001	1,543		20	77	77	109	30
31	PHONES	2001	6,529		20	326	326	435	31
32	SECURITY CAMERAS	2001	1,770		20	89	89	111	32
33	BOILER	2002	11,259		20	938	938	938	33
34	TOTAL (lines 1 thru 33)		$ 417,162	$ 73,425		$ 20,978	$ (52,447)	$ 44,095	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 417,162	$ 73,425		$ 20,978	$ (52,447)	$ 44,095	1
2	BOILER	2002	10,623		20	885	885	885	2
3	HVAC	2002	1,490		20	99	99	99	3
4	BORDERS	2002	1,110		20	111	111	111	4
5	LIGHTING	2002	4,542		20	303	303	303	5
6	ELEVATOR	2002	11,735		20	538	538	538	6
7	PAINTING	2002	5,425		20	4,521	4,521	4,521	7
8	PLUMBING	2002	2,500		20	139	139	139	8
9	PAGING SYSTEM	2002	1,637		20	136	136	136	9
10	PARKING LOT DESIGN	2002	1,610		20	33	33	33	10
11	FLOORING	2002	17,178		20	763	763	763	11
12	PAINTING	2002	24,750		20	14,438	14,438	14,438	12
13	WATER HEATER	2002	3,401		20	165	165	165	13
14	PARKING LOT SURVEY	2002	1,175		20	11	11	11	14
15	TOPOGRAFYC SURVEY	2002	2,679		20	26	26	26	15
16	DESIGN PARKING LOT	2002	1,365		20	10	10	10	16
17	ARCHITECT FEE PARKING	2002	963		20	5	5	5	17
18	ROOFING	2002	26,500		20	85	85	85	18
19	HVAC	2002	966		20	23	23	23	19
20	COOLING TOWER	2002	1,474		20	25	25	25	20
21	COOLING TOWER	2002	533		20	9	9	9	21
22	WATER TEMP CONTROL	2002	907		20	13	13	13	22
23	HVAC	2002	986		20	16	16	16	23
24	ELEVATOR	2002	1,450		20	12	12	12	24
25	PIPING	2002	1,386		20	10	10	10	25
26	PUMPING SYSTEM	2002	1,620		20	14	14	14	26
27	WIRE GLASS	2002	581		20	5	5	5	27
28	WINDOWS	2002	1,036		20	9	9	9	28
29	WIRE GLASS	2002	1,297		20	11	11	11	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 548,081	$ 73,425		$ 43,393	$ (30,032)	$ 66,510	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	CCI		1996		$	$ 1,217	35	$ 1,356	$ 139	$	4
5	CCI		2002		26,492	50	35	74	24	74	5
6											6
7											7
8											8
	Improvement Type**										
9	Care Centers allocation			2002	24,529	46	20	102	56	102	9
10	Care Centers allocation			2002		451	20	31	(420)		10
11	Care Centers allocation			2001		1	20	7	6		11
12	Care Centers allocation			2000		1	20	3	(2)		12
13	Care Centers allocation			1999		22	20	43	21		13
14	Care Centers allocation			1998		9	20	18	9		14
15	Care Centers allocation			1997		87	20	175	88		15
16	Care Centers allocation			1996		227	20	347	120		16
17	Care Centers allocation			1997		1	20	29	28		17
18	Care Centers allocation			1994		11	20		(11)		18
19	Care Centers allocation			1993		5	20		(5)		19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 51,021	$ 2,128		$ 2,185	$ 53	$ 176	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 323,486	$ 123,396	$ 28,467	$ (94,929)	10	$ 80,512	71
72	Current Year Purchases	167,999	3,201	16,819	13,618	10	27,538	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 491,485	$ 126,597	$ 45,286	$ (81,311)		$ 108,050	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Centers allocation			$ 30,790	$ 5,180	$ 4,487	$ (693)	5	$ 16,838	76
77	Pinnacle Care allocation			68,054	13,732	10,107	(3,625)	5	13,647	77
78	Facility	Bus Purchase	2001	52,634	7,519	5,263	(2,256)	5	10,526	78
79										79
80	TOTALS			$ 151,478	$ 26,431	$ 19,857	$ (6,574)		$ 41,011	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	1,210,268	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	226,453	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	108,536	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(117,917)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	215,571	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: American National Bank & Trust Co. as trustee for Trust No 25-6859

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		271	6/30/99	$ 1,256,476			3
4	Additions							4
5	Care Centers allocation				5,209			5
6	Pinnacle Care allocation				12,699			6
7	TOTAL		271		$ 1,274,384 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: after 12/1/2005 for $13,956,500 *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 17,237 Description: Copier $5810, Time Clock $2331, Pinnacle alloc $1910, Care Centers alloc $3787, Off-Site Storage $3399
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility (Jan-May)	Toyota	$ 549.98	$ 2,750	17
18	Facility (Jul-Dec)	GMAC	790.48	4,743	18
19					19
20					20
21	TOTAL		$ #######	$ 7,493	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 168,798	$		$ 168,798	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			11,744			11,744	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			133,032			133,032	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				239,366		239,366	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental	39 - 01, 02		98,435			117,789		216,224	13
14	TOTAL			$ 98,435		$ 313,574	$ 357,155		$ 769,164	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,600	$	1
2	Cash-Patient Deposits	85,846		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,000,014		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	252,121		5
6	Prepaid Insurance	107,621		6
7	Other Prepaid Expenses	10,015		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	97,163		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,555,380	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,650		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	450,898		15
16	Equipment, at Historical Cost	524,858		16
17	Accumulated Depreciation (book methods)	(282,547)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 718,859	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,274,239	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,512,243	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	78,022		28
29	Short-Term Notes Payable	1,900,000		29
30	Accrued Salaries Payable	185,710		30
31	Accrued Taxes Payable (excluding real estate taxes)	85,035		31
32	Accrued Real Estate Taxes(Sch.IX-B)	120,737		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	114,951		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,996,698	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	115,993		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 115,993	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,112,691	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 161,548	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,274,239	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 371,017	1	
2	Restatements (describe):		2	
3	**Rounding**	5	3	
4	**Adjust Accumulated Depreciation to GAAP Schedule**	5,502	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 376,524	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(134,526)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(80,450)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (214,976)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 161,548	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,243,750	1
2	Discounts and Allowances for all Levels	(1,962,938)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,280,812	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,466,688	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,466,688	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	282,078	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,451	19
20	Radiology and X-Ray	9,193	20
21	Other Medical Services	554,964	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 888,686	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,275	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,275	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,643,461	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,555,268	31
32	Health Care	3,883,186	32
33	General Administration	1,673,072	33
	B. Capital Expense		
34	Ownership	1,714,322	34
	C. Ancillary Expense		
35	Special Cost Centers	803,766	35
36	Provider Participation Fee	148,373	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,777,987	40
41	**Income before Income Taxes (line 30 minus line 40)****	(134,526)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (134,526)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,422	2,605	$ 83,353	$ 32.00	1
2	Assistant Director of Nursing	2,287	2,459	66,403	27.00	2
3	Registered Nurses	29,804	32,047	873,923	27.27	3
4	Licensed Practical Nurses	26,489	28,483	728,886	25.59	4
5	Nurse Aides & Orderlies	115,926	124,651	1,310,083	10.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,171	4,485	98,435	21.95	7
8	Rehab/Therapy Aides	11,520	12,387	157,808	12.74	8
9	Activity Director	2,440	2,623	34,760	13.25	9
10	Activity Assistants	13,630	14,656	131,175	8.95	10
11	Social Service Workers	12,380	13,312	180,417	13.55	11
12	Dietician					12
13	Food Service Supervisor	4,483	4,821	82,528	17.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,962	37,593	278,566	7.41	15
16	Dishwashers					16
17	Maintenance Workers	6,568	7,063	103,395	14.64	17
18	Housekeepers	24,820	26,688	203,096	7.61	18
19	Laundry	13,443	14,455	95,836	6.63	19
20	Administrator	3,214	3,456	86,745	25.10	20
21	Assistant Administrator	844	907	18,469	20.36	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,926	6,372	100,224	15.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,634	2,617	23,551	9.00	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,579	3,848	32,094	8.34	33
34	TOTAL (lines 1 - 33)	321,542	345,528	$ 4,689,747 *	$ 13.57	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	302	$ 12,096	01-03	35
36	Medical Director	monthly	33,000	09-03	36
37	Medical Records Consultant	monthly	4,128	10-03	37
38	Nurse Consultant	31	1,563	10-03	38
39	Pharmacist Consultant	monthly	4,878	10-03	39
40	Physical Therapy Consultant	85	4,252	10a-03	40
41	Occupational Therapy Consultant	99	4,963	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	monthly	2,496	11-03	44
45	Social Service Consultant	112	5,965	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	629	$ 73,341		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	198	3,950	10-03	52
53	TOTAL (lines 50 - 52)	198	$ 3,950		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Claussen	Administrator	0	$ 86,745
Barry Gans	Asst. Admin.	35.42%	18,469
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 105,214

B. Administrative - Other

Description	Amount
Management Fees - Eric Rothner	$ 60,000
Management Fees - Barry Gans	96,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 156,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 28,160
Care Centers Inc	Accounting	13,750
Care Centers Inc	Bookkeeping	51,662
Alpha Data	Data Processing	3,083
Paychex	Data Processing	6,058
Kronos	Data Processing	2,609
Keane Care	Data Processing	541
Optimizer Systems	Data Processing	125
Pinnacle Care	Home Office Expense	89,280
see attached	Legal	11,280
Personnel Planners	Unemployment Consult	2,797
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 209,345

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,271
Unemployment Compensation Insurance	31,568
FICA Taxes	350,760
Employee Health Insurance	161,684
Employee Meals	47,304
Illinois Municipal Retirement Fund (IMRF)*	
Misc. Employee Welfare	5,892
Pension Expense	38,457
Christmas Expense	1,145
TOTAL (agree to Schedule V, line 22, col.8)	$ 717,081

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,438
Health Care Worker Background Check	300
(Indicate # of checks performed 25)	
Dues & Subscriptions	12,406
Licenses & Fees	1,284
Advertising & Promotion	23,793
Yellow Page Advertising	1,098
Care Centers allocation	1,511
Pinnacle Care allocation	1,277
Less: Public Relations Expense	( )
Non-allowable advertising	(23,793)
Yellow page advertising	(1,098)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,216

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,675
Care Centers allocation	1,299
Pinnacle Care allocation	3,608
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,582

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PINNACLE HEALTH CARE # 0044453 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $15,181**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,795** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **148,373**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **47,304** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees